Joint submission

"A Strategic Framework for the Human Resources for Health Plan: Draft for Discussion"

14 September 2005

Drafted by:

Jonathan Berger
(011) 717-8627 (t)
(011) 403-2341 (f)
bergerj@law.wits.ac.za

Adila Hassim
(011) 717-8637 (t)
(011) 403-2341 (f)
hassima@law.wits.ac.za

INTRODUCTION

The AIDS Law Project ("the ALP") and the Treatment Action Campaign ("the TAC") welcome the release of the *Strategic Framework for the Human Resources for Health Plan* ("the Strategic Framework") for public comment and discussion. We further welcome the express acknowledgement therein by the Department of Health ("the DoH") of the need for appropriate human resources for health (HRH) planning and recognise the substantial work that has gone into the development of the Strategic Framework.

However, we are concerned about a number of issues, both in relation to the substance of the Strategic Framework as well as the process by which it has been developed. While this submission will focus on the key substantive concerns raised by the Strategic Framework, it is important that we also place our reservations regarding the process on record. In short, the process followed to date has been flawed in the following ways:

- Despite expecting an HRH plan to be released at the end of March 2005, as initially promised by the DoH, the Strategic Framework was only released some four months later on 3 August 2005, calling for public comments within a six week period.

- At the time the Strategic Framework was released, the draft Health Charter had been in circulation for just over three weeks, with public comments on that document being due less than two weeks later on 15 August 2005.

- Neither the ALP nor the TAC was invited to attend the briefing sessions on the Strategic Framework organized by the DoH during the week 11 – 17 August 2005, despite the DoH's knowledge of our interest in the matter and the need for broad consultation with civil society organisations that act and/or speak on behalf of users of health care services.

These flaws needn't be fatal. While an HRH plan should be finalised as soon as is reasonably possible, there is a need to consult more broadly and appropriately with organisations such as ours as well as other key stakeholders such as health sector trade unions, tertiary institutions, nursing colleges and appropriate statutory councils. Such consultations should take place in an open and accountable manner, possibly in the form of public hearings co-ordinated by Parliament's Portfolio Committee on Health.

Our key concerns relating to the substance of the Strategic Framework can be summarised as follows:

- It is not a national HRH plan;

- It fails to recognise the relationship between HRH planning and health sector transformation, and to give substantive meaning to the concept of national stewardship of HRH planning;

- It fails to deal with emergency and short-term needs as integral parts of HRH planning;

- It is devoid of priority setting; and

- It fails to address other key issues such as:

    - Inter-sectoral cooperation;
    - The setting of health care worker (HCW)/patient ratios;
    - Why many HCWs are leaving the public sector;
    - The impact of HIV/AIDS on individual HCWs and the health system as a whole;
    - The financing of HRH planning;
    - Determining an appropriate role for the private sector; and
    - Monitoring, evaluating and ensuring the proper implementation of a national HRH plan.

But before commenting in further detail on these key concerns, we believe it is important briefly to consider the context that demands appropriate HRH planning, as well as to set out the relevant constitutional and statutory framework within which the HRH plan is to be located.[1] This focus considers the constitutional requirement to develop and implement a national HRH plan, the requirements regarding the substance of such a plan, and various statutory requirements as set out in the National Health Act, 61 of 2003 ("the NHA"). Once this is done, the submission considers the manner in and the extent to which the Strategic Framework fails to comply with the constitutional and statutory requirements and how it could be improved to address its shortcomings.

THE RELEVANT CONTEXT

Chapter Three of the Strategic Framework captures the key HR challenges that confront the health sectors, both public and private. These challenges, which include issues such as the appropriate skills mix, the distribution of HCWs, staffing norms, education and training, developing new categories of HCWs, and management and supervision, were all identified as far back as 2001 in the DoH-commissioned report entitled "Human Resources for Health in South Africa: A National Strategy" ("the Pick Report").[2] Simply put, the HRH crisis is nothing new.

A central aspect of the HRH crisis is the migration of HCWs from the public to the private sector, as well as from both sectors to countries abroad. South Africa already understands, as highlighted in the recently published 2005

[1] This submission does not deal with every relevant constitutional provision, such as sections 195 and 237, which deal with the following issues respectively:

- Basic values and principles governing public administration; and
- The diligent performance of obligations: "All constitutional obligations must be performed diligently and without delay."

[2] William Pick et al, "Human Resources for Health in South Africa: A National Strategy" ("the Pick Report") (2001)

South African Health Review ("the SAHR"),[3] that migration results from both push and pull factors. Recognising that both sets of factors need to be addressed, the 2005 SAHR highlights the two key factors (other than poor remuneration) that push HCWs out of the public sector: poor working conditions (which include issues such as poor management, stress and burnout related to staff shortages, fear for physical safety, and a lack of medical equipment and supplies), and the negative impact of HIV/AIDS.[4]

The crisis of staff shortages is reflected in the number of vacant posts in the public sector across all provinces. According to the 2003/04 SAHR, for example, all but two provinces had vacancies of more than 20% over the period 2001 – 2003.[5] Mpumalanga, most disturbingly, had more than two-thirds of its posts unfilled.[6] Such high levels of vacant posts are exacerbated by unreasonably burdensome and bureaucratic procedures ordinarily adopted for the screening, interviewing and appointment of job applicants.

With HRH challenges already well defined and understood, the development and implementation of a national HRH plan is the only logical next step. In short, such a plan must set out a comprehensive strategy for addressing each of the identified challenges, detailing steps to be taken to address emergency, short-, medium- and long-term needs.

CONSTITUTIONAL REQUIREMENT TO DEVELOP AND IMPLEMENT A REASONABLE NATIONAL HRH PLAN

The constitutional requirement to develop and implement a national HRH plan is primarily located in section 27 of the Constitution, which guarantees everyone "the right to have access to … health care services".[7] In terms of section 7(2) of the Constitution, the duty to "respect, protect, promote and fulfil the rights in the Bill of Rights" is expressly placed on the state. These obligations are both positive (requiring the state to do something) and negative (requiring the state to desist from doing something). But in respect of the right of access to health care services, the positive obligations are more narrowly defined in section 27(2), which requires the state to "take reasonable legislative and other measures, within its available resources, to achieve the progressive realization" of the right.

These positive obligations must be read in the context of a Constitution that also protects fundamental rights such as equality and non-discrimination, human dignity and life.[8] As Justice Mokgoro observed in *Khosa and Others v Minister of Social Development and Others; Mahlaule and Another v Minister of Social Development and Others*:

---

[3] Petrida Ijumba and Peter Barron, (eds.), *South African Health Review 2005* (Health Systems Trust, Durban: 2005), also available online at http://www.hst.org.za/generic/29

[4] Ibid at pages 80 – 81

[5] Ashnie Padarath et al, "Chapter 22: Human Resources" in Petrida Ijumba et al, (eds.), *South African Health Review 2003/04* (Health Systems Trust, Durban: 2004), also available online at http://www.hst.org.za/publications/423

[6] Ibid at page 304

[7] Section 27(1)(a)

[8] Sections 9, 10 and 11 respectively

> "The socio-economic rights in our Constitution are closely related to the founding values of human dignity, equality and freedom. … Equality in respect of access to socio-economic rights is implicit in the reference to 'everyone' being entitled to have access to such rights in section 27."[9]

The implications of the right to equality for socio-economic rights are set out in *Minister of Finance v Van Heerden* where Deputy Chief Justice Moseneke[10] described the Constitution as one that "commits our society to 'improve the quality of life of all citizens and free the potential of each person.'"[11] Critically, his judgment in *Van Heerden* makes it plain that positive constitutional obligations cannot simply be discharged through the progressive realisation of the relevant socio-economic right, but that policies, plans and laws must be developed and implemented in a way that does not exacerbate – but rather reduces – inequality:

> "Our supreme law says more about equality than do comparable constitutions. Like other constitutions, it confers the right to equal protection and benefit of the law and the right to non-discrimination. But it also imposes a positive duty on all organs of state to protect and promote the achievement of equality — a duty which binds the judiciary too.
>
> … Of course, democratic values and fundamental human rights espoused by our Constitution are foundational. But just as crucial is the commitment to strive for a society based on social justice. In this way, our Constitution heralds … the start of a credible and abiding process of reparation for past exclusion, dispossession, and indignity".[12]

What does this all mean for HRH planning? In order to discharge its constitutional obligations regarding health care services, the state has to ensure that all systems necessary for the delivery of health care services are put in place. This includes taking all reasonable steps to ensure that sufficient numbers of appropriately trained HCWs – including health care providers and other non-health personnel – are trained, attracted to and retained in the public and private health sectors health system to provide and manage the provision of health care services.

While the Constitution is silent on the exact nature of the health care system, it nevertheless requires that people get access to quality health care services and that over time, the disparities in access between rich and poor are reduced. In terms of HRH planning, this means whatever measures are taken to ensure that there are sufficient numbers of appropriately trained HCWs to provide and manage the provision of health care services in both public and private sectors, they should also result in narrowing the gap between rich and

---

[9] 2004 (6) SA 505 (CC) at paragraphs 40 and 42 respectively
[10] At the time, he had not yet been appointed Deputy Chief Justice.
[11] 2004 (6) SA 121 (CC) at paragraph 23
[12] Ibid at paragraphs 24 – 25 (footnotes omitted)

poor. In a country where the vast majority of the population is reliant on the public health sector, achieving substantive equality in relation to health care access requires a significant investment in the public sector to make sure that it is able to attract and retain appropriately trained HCWs.

Such desired (and constitutionally mandated) outcomes can only result from the proper implementation of a well-conceived HRH plan. A strategic framework may be useful as a first step in the development and implementation of an HRH plan, but it cannot take the place of the plan itself. Further, a plain reading of the judgment makes it clear – in the context of HRH planning, the "production" of HRH and the nature of the public and private sectors and their relationship – that such a plan must be national in its focus. While provinces certainly have important roles to play in the development and implementation of the constitutionally required plan, the complexity of the various parts of the plan and their relationship requires national co-ordination, monitoring, evaluation and oversight.

This conclusion is supported, for example, by the requirements of a reasonable plan, as largely set out in *President of the Republic of South Africa v Grootboom*:[13]

- The plan must be comprehensive and co-ordinated, with a clear allocation of tasks and responsibilities at all levels of government.

- The plan must identify (or call for) a funding mechanism that considers the quantifiable gap in the existing capacity of HRH and the health care needs of the population, and is able to deliver on the stated targets.

- "[L]egal, administrative, operational and financial hurdles should be examined, and where possible, lowered over time."[14]

- The plan must be implemented "by taking all reasonable steps that are necessary to initiate and sustain it" and "with due regard to the urgency of the situations it is intended to address."[15]

- The plan must set out how its implementation is to be measured.

In addition to these essential aspects, the relevant case law also identifies the following key requirements of a constitutionally defensible (reasonable) plan:

- It must be capable of facilitating the realization of the right of access to health care services (it must be able to achieve its aim);

---

[13] 2001 (1) SA 46 (CC). While *Grootboom* deals primarily with the right of access to adequate housing, it sets out the broad requirements of a constitutionally defensible plan arising from the state's positive obligation to take reasonable legislative and other measures, within available resources, to achieve the progressive realisation of the right. As the same obligation exists in respect of the right of access to health care services, the *Grootboom* judgment is of direct relevance to health care.

[14] Ibid paragraph 45

[15] Ibid at paragraph 67

- It must be balanced and flexible, making provision for short, medium and long terms needs, as well as including a component that responds to the urgent needs of those in desperate situations;

- Implementation of the plan must be expeditious and efficient, be done in a transparent manner; and

- In order for the optimal implementation of the plan, its contents must be made known to all stakeholders, through "proper communication, especially by government".[16]

In other words, a reasonable plan has to set out – in sufficient detail – what needs to be done to achieve the desired outcome whilst at the same time being sufficiently flexible to respond to emergencies and other short-term needs. Attention needs to be given to its development, implementation and monitoring, with the latter two aspects influencing the initial substance of the plan itself as well as later revisions.

THE NHA AND A NATIONAL HRH PLAN

In many respects, chapter 7 of the NHA – which deals with "human resources planning and academic health complexes" – sets out the skeleton of a national HRH.[17] It is very much in line with what the Constitution requires, giving significant detail about the roles to be played by various national bodies and persons in the development, implementation and monitoring of HRH planning. In brief, the National Health Council ("the NHC") develops national policy and guidelines on HRH, the Forum of Statutory Health Professional Councils ("the FSHPC") advises the Minister of Health ("the Minister") on various aspects of health professions including key elements of HRH planning, and the Minister makes regulations "regarding human resources within the national health system".

The roles to be played by the provinces and health districts are set out – in part – in chapter 7, as well as in chapter 4 (dealing with provincial health), chapter 5 (dealing with the district health system):

- Chapter 7: Section 49 of the NHA (dealing with "[m]aximising [the] services of health care providers") mandates the Minister of Health, **"**with the concurrence of the National Health Council", to "determine guidelines to enable the provincial departments and district health

[16] *Minister of Health v Treatment Action Campaign (No 2)* 2002 (5) SA 721 (CC) at paragraph 123.

[17] This is recognised by the Strategic Framework itself (at page 41). Further, in a briefing on the National Health Act (dated 19 August 2004), the Minister of Health stated that the NHA "mandates the national Department to develop a human resources policy and guidelines to ensure adequate distribution of health personnel, to provide for trained staff at all levels of the health system and to ensure the effective utilization of health personnel." The text of the briefing is available online at http://www.doh.gov.za/docs/pr/2004/pr0819.html.

councils to implement programmes for the appropriate distribution of health care providers and health workers."[18]

- Chapter 4: Provincial health departments are mandated by section 25(2)(i) to "plan, manage and develop human resources for the rendering of health services".

- Chapter 5: "The "relevant member of the Executive Council" in each province is mandated by section 33(2) to "ensure that each health district develops and implements a district human resource plan in accordance with national guidelines issued by the Director-General."[19]

Role of the NHC

Section 48(1) of the NHA, which deals with the "[d]evelopment and provision of human resources in [the] national health system", requires the NHC to "develop policy and guidelines for, and monitor the provision, distribution, development, management and utilisation of, human resources within the national health system." Subsection (2) speaks about the "policy and guidelines" facilitating and advancing a number of objectives, including:

- "the adequate distribution of human resources"

- "the provision of appropriately trained staff at all levels of the national health system to meet the population's health care needs";[20] and

- "the effective and efficient utilisation, functioning, management and support of human resources within the national health system."

Simply put, the NHA envisages a powerful role for the NHC in the development, implementation and monitoring of a national HRH plan.

Role of the FSHPC

In certain key ways, the HRH planning work of the NHC and the Minister is to be supported by the FSHPC, which has yet to come into existence.[21] Its duties include various HR-specific matters, including obligations to:

---

[18] In our view, the "appropriate distribution of health care providers and health workers" can only take place if HCW/patient ratios have been established, which in turn are reliant on a thorough assessment of patient needs.

[19] Section 33 deals with the "[p]reparation of district health plans".

[20] In this regard, kindly refer to pages 5, 7 and 8 of our attached submission to the DoH regarding the draft Health Charter. These pages deal with the issue of a defined minimum package of care necessary "to meet the population's health care needs".

[21] Chapter 7 of the NHA was one of ten chapters of the statute that came into force on 2 May 2005. However, sections 50 (dealing with the FSHPC) and 51 (dealing with academic health complexes) have yet to be proclaimed. In her 19 August 2004 briefing on the National Health Act (see above note 17), the Minister of Health stated that "[t]he only reason that will delay the immediate establishment of the Forum of Statutory [Health Professional] Councils is the fact that the various councils will have to convene meetings to elect their representatives on the Forum and make their nominations to the Minister."

- "advise the Minister on the development of coherent policies relating to the education and training and optimal utilisation and distribution of health care providers";[22]

- "monitor and advise the Minister on the implementation of health policy in so far as it impacts on health care providers and the registered professions";[23]

- "advise the Minister and the individual statutory health professional councils" on a range of issues including "the scopes of practice of the registered professions",[24] "common educational and training requirements of health care providers",[25] and "the recruitment, evaluation and registration of foreign health care professionals".[26]

Importantly, the FSHPC is empowered by section 50(5)(a) to "consult or hear representations by any person, body or authority" and to "establish a committee to advise it on any matter".

Role of the Minister

Section 52 of the NHA sets out the power of the minister to make HRH-related regulations, which deal with matters such as resource allocation for education and training,[27] "strategies for the recruitment and retention of health care personnel",[28] and ensuring the existence of and the availability of institutional capacity for HRH planning at national, provincial and district levels.[29] When read together with the provisions dealing with the NHC, the FSHPC, the provinces and health districts, the regulations envisaged by the NHC will provide a detailed regulatory framework for HRH planning at national, provincial and district levels. In addition, the development and implementation of the regulations anticipates active involvement of the NHC, the FSHPC (with the input of public consultation and expert committees) and provincial and district health authorities.

IN WHAT KEY WAYS DOES THE STRATEGIC FRAMEWORK NOT COMPLY WITH THE CONSTITUTIONAL AND STATUTORY FRAMEWORK AND HOW COULD IT BE BETTER?

In general, we do not have many concerns regarding the substance of the Strategic Framework. Other than the issues of flexibility and the lack of priority setting (discussed below), our concerns are primarily limited to the nature of the document (it is a broad framework – lacking in appropriate detail – and not a national HRH plan) and the key issues that it fails to address

[22] Section 50(4)(i)
[23] Section 50(4)(j)
[24] Section 50(4)(n)(i)
[25] Section 50(4)(n)(ii)
[26] Section 50(4)(n)(vii)
[27] Section 52(a)
[28] Section 52(e)
[29] Section 52(f) and (g)

(such as the relationship between such a plan and substantive health sector transformation).[30]

On the issue of flexibility, a constitutional requirement, we have two concerns. First, the Strategic Framework appears to suggest once-off planning without any attention being paid to in-built processes of monitoring, evaluation and revision of the framework itself. Second, it deals only tangentially with emergency and short-term needs, which are seen as falling outside of any systematic and comprehensive HRH planning process. In our view, based in large part on the Constitutional Court's understanding of a reasonable (and constitutionally defensible) plan, dealing with emergency and short-term needs will always have to be seen as an integral part of HRH planning.[31] *Grootboom* makes it plain that the needs of the most urgent must be prioritised.

On priority setting more broadly, the eight guiding principles of the Strategic Framework are presented in a way that suggests that they are of equal importance, a conclusion that is not justified by the health needs of the country or the state's obligations as entrenched in the Constitution. While we have no problem with – and indeed support – the substance of the identified principles, we do not support them forming the core pillars of a national HRH plan. Certain of them may be condensed into one (such as guiding principles 2 and 6 dealing with global health issues) and perhaps downgraded, whereas others need to be expanded and prioritised (such as guiding principle 8 dealing with conducive work environments) to include concerns relating to appropriate terms and conditions of service in the public sector.

Our analysis of the Strategic Framework has identified eight key omissions:

First, while it places much emphasis on the principle of stewardship and the role of the DoH in this regard, it avoids any substantive engagement with the support, co-ordination and oversight roles of the national government that are clearly set out in the provisions of the NHA referred to earlier. Instead, the Strategic Framework is vague on process and the manner in which HRH planning is to proceed. In our view, which is based on what the Constitution and the NHA require, the process needs to deliver a national HRH plan that is supported and – in part – implemented through the development and promulgation of regulations in terms of section 52 of the NHA.

Second, it provides no indication of any attention having been given to inter-sectoral cooperation in the development and implementation of an HRH plan. An integrated strategy, which is necessary to address the multiple challenges of HRH planning, goes beyond education and training, extending to financing

[30] In this regard, kindly refer to our attached submission to the DoH regarding the draft Health Charter.

[31] Current emergency needs include the appropriate use of private general practitioners to provide public services (such as antiretroviral (ARV) treatment) in areas where the public health system is currently lacking in capacity to provide such services. Current short-term needs include the training of health care providers on key aspects of the ARV treatment protocols.

(treasury), terms and conditions of employment (labour and public service and administration) and physical infrastructure (public works).[32]

Third, it fails to set actual HCW/patient ratios, instead casting doubt on the need for such ratios at all.[33] In our view, the document conflates the need for ratios per se with the establishment of blanket ratios that do not deal with factors such as the burden of disease. Ratios are not only integral to HRH planning as a means of assessing existing capacity; but also to provide targets that are central to monitoring and evaluating the implementation of an HRH plan.

Fourth, the Strategic Framework does not deal with the fundamental reason why many HCWs are leaving the public sector, one of the primary causes of the HRH crisis in South Africa. If it were to deal with this, the Strategic Framework would have to address the following issues (at least):

- Career pathing (including professional development and on-the- job training), performance-based incentives and other mechanisms for attracting HCWs (especially health care providers) to and retaining them in the public sector;

- Re-evaluation of the rural and scarce-skills allowances which do not appear to be achieving their objectives, alongside the consideration of other incentive schemes or mechanisms to achieve the same desired outcomes;

- Access to health care services for HCWs; and

- The improvement of public health facilities, including the concerns of HCWs relating to education, housing and safety and security. Quite clearly, this would require an inter-sectoral response.

Fifth, the Strategic Framework does not prioritise – let alone consider in any detail – dealing with the impact of HIV/AIDS, the most significant threat to the equitable provision of quality health care services in the public health system. As far back as 2001, the Pick Report already identified three levels of HIV/AIDS impact that will affect a national HRH strategy:

---

[32] The need for a co-ordinated strategy was recognised by President Mbeki during the opening of Parliament in 1999:

> "The integration we seek must, for instance, ensure that when a clinic is built, there must be a road to access it. It must be electrified and supplied with water. It must have the requisite personnel, qualified to meet the health needs if [sic] the particular community. The safety and security of the personnel and material resources, which are part of the clinic, must be guaranteed. We must also establish the conditions which give the possibility to this medical point to radiate outwards as a point of reference with regard to the larger project of our self-definition as a people at work, building a better life for ourselves."

See "State of the Nation Address" (25 June 1999), quoted in the Pick Report, above note 2 at page 1.

[33] At pages 27 to 29

- Decline in population growth;
- Increased burden on health services; and
- Increased illness and death amongst health care workers and health sciences students.[34]

Including and in addition to these, the Strategic Framework should consider and explore solutions to dealing with the following concerns:

- The increased demand of the burden of HIV disease on the public health system that will remain until the *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa* ("the Operational Plan") is more fully implemented;
- The increased demand on HRH of the Operational Plan itself, particularly during the period leading up to its full implementation;
- The shortage and/or maldistribution of particular categories of HCWs, such as nurses and pharmacists, necessary for the successful implementation of the Operational Plan;
- The potential impact of an estimated 15.7% HIV prevalence amongst HCWs on service delivery;[35] and
- Access to prevention (post-exposure prophylaxis following needlestick injuries) and antiretroviral (ARV) treatment services for HCWs.

Sixth, the Strategic Framework does not consider how the HRH plan should be financed (conditional grants (from the DoH and/or other relevant departments, such as education), equitable shares or a combination of both), how (and by whom) HRH expenditure should be monitored, or what mechanisms are needed to improve financial management. It also makes no attempt to establish the financial costs of implementing an appropriate national HRH plan or even the budgetary implications of proposals made. Instead, we note – with concern – that the Strategic Framework assumes that the "country has the necessary financial resources to implement the national human resource plan".[36] No reasons are advanced for this assumption.

Seventh, in acknowledging that the private sector will have to play a role in the implementation of an HRH plan, the Strategic Framework provides no clarity on the actual role of the private sector in this regard. Instead, it is silent on the way in which the significant proportion of HRH capacity that already exists in the private sector may be harnessed for the provision of public health care

[34] See Chapter 4 (The impact of HIV/AIDS) of the Pick Report, above note 2
[35] See Olive Shisana et al, *The Impact of HIV/AIDS on the Health Sector: National survey of health personnel, ambulatory and hospitalised patients and health facilities 2002* (Human Sciences Research Council, Medical University of Southern Africa and the Medical Research Council, 2003)
[36] At page 12

services. This is an area that the Pick Report identifies as in need of further investigation.

Finally, the Strategic Framework does not address a fundamental aspect of any reasonable plan – implementation. If it were to address implementation, it should – at the very least – address the following issues:

- Defining a methodological approach to identifying health needs as a prerequisite for identifying the HRH necessary to satisfy such needs; and

- Determining appropriate benchmarks and indicators to provide a basis for necessary monitoring and evaluation of the implementation of the HRH plan itself, whether by government, civil society or both.

CONCLUSION

The World Health Organization's 2000 World Health Report recognises that human resources "are the most important of the health system's inputs" and that the "performance of health systems depends ultimately on the knowledge, skills and motivation of the people responsible for delivering services."[37] We agree. We also believe that between government, labour, civil society and the private sector, we have sufficient information to embark immediately on the process of developing a national HRH plan. Together, the Pick Report, the 2005 SAHR and the Strategic Framework (including various stakeholder inputs such as this submission) provide a sufficient basis for urgent action. We trust that the call for submissions on the Strategic Framework is only the first step in a broad consultative process that will assist the DoH and the Minister in delivering on their constitutional and statutory duties.

Johannesburg
14 September 2005

[37] "Chapter 4: What resources are needed?" in *The World Health Report 2000 – Health Systems: Improving Performance* (World Health Organization, Geneva: 2000) at page 77